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The Madras Clinical Journal

JOURNAL OF THE MADRAS STATE BRANCH OF THE INDIAN MEDICAL ASSOCIATION
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Vol. XXIX April 1963 No. 10

OPERATIVE TREATMENT OF POTT'S SPINE

(PRELIMINARY BRIEF REVIEW OF TEN CASES OPERATED IN ONE YEAR)

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It is proposed to review the results of the thirty cases of Pott's spine with or without paraplegia treated in my unit in a term of one year either by operation or otherwise and therefrom share my views with you. I shall not go into pedantic discussions on the evolution and merits and demerits of the whole problem which the reader can easily pick up from any text-book. Our problems have been unique in India as much as it concerns the economic status of the individual who suffers from the disease on the one hand and the hospital bed availability on the other hand. To draw any dogmatic conclusions from a small series as this would be unscientific and unprofitable, but certain questions can be answered in a bewildering subject like Pott's spine which is so common and yet whose treatment is not standardised in our parts as yet.

We live in a world of rapid changes. Although scientific thoughts are never static, they have their own progress and regression at various times. Our interest has been always to give the suffering patient the much desired relief in as short a time as possible and save much of the economic drain associated with it. In that perspective the management of Pott's spine has seen much progress to cut short the time of treatment to the bare minimum. Our forefathers treated these cases by simple immobilisation and rest — may be for 9 months to 1½ years and the mortality rate was 30%. Streptomycin, PAS and INH still revolutionised the outcome of this disease. Now we are on the threshold of operation for all cases of Pott's spine with and without paraplegia as advocated by the Americans on the one side, and operations only in resistant cases of Pott's paraplegia as advocated by the British surgeons on the other side, and the age long conventional conservative treatment by many.

The total number of cases seen in one year are thirty (cases) of Pott's spine and these were treated either conservatively or by operation.

A broad review will be:

21 cases treated conservatively.

9 cases (10 operations) operated

Costo – transversectomy – 5 cases.

Antero-lateral decompression – one

Anterior thoracotomy and spinal fusion – one.

Thoracotomy and curettage – three

Mortality out of 10 operations – one case died of hypostatic pneumonia.

Out of the 10 operations, 6 cases were operated for Pott's spine with paraplegia which has lasted for more than 2 months. 3 cases were operated for Pott's spine without paraplegia but with well-marked paravertebral abscess.

Out of 21 cases treated conservatively, only two had paraplegia and they refused operations; the other cases were spinal tuberculosis with paravertebral abscess. These patients were admitted in the hospital and immediately given anterior and posterior plaster shells on which they have to lie and change their position once in 4 hours to avoid developing bed-sores and to facilitate nursing. They were also given streptomycin 1 gm daily and INH 100 mgm thrice daily and special diet. On an average they are kept for 60 days in the ward and then discharged with plaster jacket to attend as out-patient. Blood sedimentation rate and regular radiographic check ups are maintained. One patient developed meningitis during treatment and was controlled with the same treatment of streptomycin and INH only.

Age	Male	Female	No. of Pott's spine	With Paraplegia
5 — 15 Years	1	9	8	2
16 — 30 ,,	3	8	7	4
31 — 50 ,,	3	6	6	3

Analysis:— Incidence appears more frequent in the age group of 5 — 15 years and 16 — 30 years and women suffer predominantly more than men. It is also observed that the level of the lesion is lumbar in most of the children and in other cases the level is in the thoracic vertebrae $D_6 - D_{11}$ level. Cervical lesions are not common and only two cases were seen in this series. Pregnancy certainly influences the course of the disease and three of the cases developed paraplegia after confinement or the symptoms worsen after confinement.

Result of conservative treatment:— Most of these patients are without paraplegia but with well marked paravertebral abscess or psoas abscess. So long as they are in the hospital, patients take the injections and adhere to the diet very strictly; but we find that patients do not confine themselves to strict recumbency and to the use of the shell. They are disciplined during ward rounds and at other times they have freedom of movements on the sly. In spite of ourselves establishing a library mainly for the orthopaedic patients and books being donated by the USIS, Madras, very few avail the facility; certainly a few do keep to reading and confine to plaster shell. So we are not sure whether we have achieved results through rest. Again when patients are discharged home

with plaster jacket, we find them reporting with tottered jackets and ill-kept plaster either through negligence or because of bed bug nuisance. We certainly accept that a good number of persons keep the jacket trim and neat. With all these shortcomings in conservative treatment that is peculiar to our conditions, we do get good results and evidence of progressive healing and sclerosis and subjective improvement in the general condition and reduction in blood sedimentation rate; of course others who come with torn plaster jacket come with marked kyphus deformity. In general it takes more than a year to discharge the patient from our review and some feel it uueconomical to come for review out-patient and these patients are sent away with a long Taylor's brace. A correct assessment of the final result in these cases is possible only in a few cases drawn from the city itself.

Of the two cases with paraplegia treated conservatively, one showed improvement in one month and in another it is now 9 months and still motor power has not reappeared, though radiologically there is resorption of the paravertebral abscess. In this connection I would like to mention that my colleague, Dr. S. V. K. S. Thangarajan often times remarks that conservative treatment in tuberculosis of the spine with paraplegia has effected very good results and he has treated five cases in a term of 3 years and the patients recovered from paraplegia from 3 months to 9 months time and were followed later with plaster immobilisation and observed for 1½ years. It is most certainly worth considering especially in a private practice as his, in the sense that most of these private patients are drawn from the middle and upper class and are fairly educated to follow instructions and to submit for repeated observations and they always hesitate to accept the idea of operation in any circumstance and they re-assure the doctor that time is of no consequence for them, if we promise that conservative treatment will bear fruit in the end.

Analysis of operated cases: We see that a number of operations of different kinds have been undertaken. But the criteria for me to start with was simply the question of an easy approach to the problem by first doing simple costo-transversectomy and them slowly progressing to thoracotomy as my confidence and belief strengthened rather than any other consideration. I must stress that these operations can be undertaken only on the strength of having hospital facilities like efficient controlled anæsthesia, a good physiotherapy department and nursing care and the services of a thoracic surgeon in the initial periods. Of course I was fortunate to have Dr. Thyagarajan (now at Coonoor), a trained thoracic surgeon (Sheffield) who helped me a great deal in the thoracic approach. Though my first few cases were costotransversectomies, later on I did only thoracotomy and evacuated the abscess and I can safely say that the thoracic route has an easier technical approach and a greater accessibility and control of the operative area than the other operations which were technically more difficult and bloody.

Five costo-transversectomies were done for 4 cases; one case required on both sides and out of these 3 cases showed immediate improvement in the recovery of the sensory loss and in a duration of 3 months time, the patients were well up and walking and reporting to us with

infinite gratitude. We fit them with a long Taylor's brace for some more time. The results were dramatic and their hospital stay was only 2 to 3 months and the disability with paraplegia was only 3 months. Though we would very much like them to be recumbent for a few more months till good consolidation is revealed radiologically, they do not often follow our advice because of their economic or social status which these hospital class of patients do not enjoy in abundance. One case of costo-transversectomy done in a female patient 50 years of age with a progressive deterioration of neurological deficit, died on the 3rd post-operative day suddenly due to hypostatic pneumonia. Obviously her vital capacity was not well kept up in spite of intensive pre- and post-operative chest expansion physiotherapeutic exercises.

After costo-transversectomy the bedsores often healed very well and the flexor spasms disappeared immediately. In one case of anterolateral decompression we found that the pedicle of the dorsal vertebra itself was crumbled and recovered a bony sequestrum that was hitching against the cord. In an anterior approach by thoracotomy, we scooped out the debris and put the excised rib as a graft between the vertebra after hyperextension of the spine and as seen in the radiograph, it was smugly placed. The patient was well on the way of recovery and was discharged from hospital after two months and he never reported later. Of course the other cases were for non-paraplegic patients and the results were very gratifying as assessed by the shortening of their hospital stay and improvement in their general condition. We could have done more cases but for lack of accommodation in a hospital mainly intended for traumatic cases and besides our special work in internal fixation of fractures and hand clinic occupy more time besides our work outside.

We certainly feel that by operation in Pott's spine with paraplegia, we have achieved very good end results in a very dramatic way in a short time and the annoying bed sores and urinary incontinence were remedied for good. We have saved much of hospital stay time and also allayed the fear of the patients - mostly women - that family circumstances will not permit them to be away from home longer. In one case a girl just married was admitted under us with Pott's spine with paraplegia, the husband threatened to marry another girl; here operation proved a boon to the girl and after 3 months, she reported to me walking into the department with a broad smile and my first question was, 'How, is your husband?' She was happy to say that they are getting on very well. Operation in non-paraplegic Pott's spine, we feel that the same rapid convalescence and avoidance of an imminent onset of paraplegia or of a protracted illness are achieved. I shall deal no more on this analysis and wish to share my impression that operations are a rational and more rewarding proceedure than conservative; at the same time operations are not to be undertaken without a trial of conservative treatment at least for a period of 6 weeks.

Discussion : Reviewing the colossal volume of work done by the various orthopaedic surgeons on either side of the Atlantic, one certainly gains the impression that the poor quality of recovery of paraplegia in Pott's disease by conservative treatment had influenced the surgeons to try

the operation of decompression. The decision is taken when the paralysis has increased or remained stationary despite adequate fixation, or severe flexor spasm precludes immobilisation. Seventy five percent of operated cases do show complete neurological recovery. Operations done late in the disease do not show convincing results.

While an abscess, whether a cold abscess or a pyogenic abscess in any other situation, carried an axim "let out the pus", are we withholding this procedure in Pott's spine because of its deep seated, inaccessible position? Earlier the pus is let out and the cavity curretted, the better it is for the patient in reducing his toxemia and spread to the other vertebrae. It should be treated strenuously by open drainage and removal of necrotic tissue–aspiration alone is inadequate. This is also important in the prevention of a late onset of paraplegia.

I thank the Superintendent, Erskine Hospital for permission to use the hospital records and Dr. G. Victor, President of Erskine Hospital Clinical Society for permitting me to publish the review I presented in that society on one occasion. I thank Mr. S. Thyagarajan for his help during the operation and Dr. Kalidoss for his valuable help and Mr. S. V. K. S. Thangarajan for constantly discussing with me on the disputed points. Last but not the least, my thanks to Mr. Sundaravenkatakrishnan for his help in the management of these cases.

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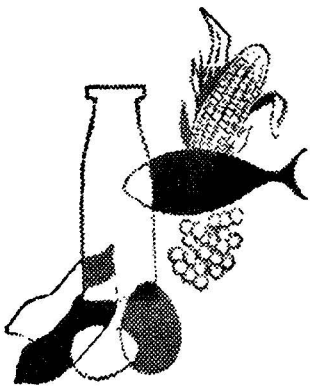

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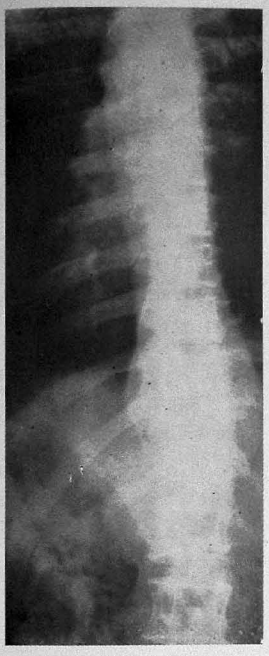

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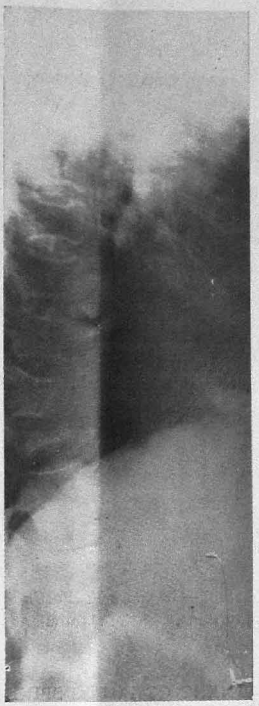


FIG. 2.

FIG. 3.

Figs 1 & 2: Mariammal — Pott's spine with paraplegia (15—3—'62)

Fig. 3: Mariammal — Thoracotomy and anterior fusion done — Rib graft shown by the arrow (4—4—'62)

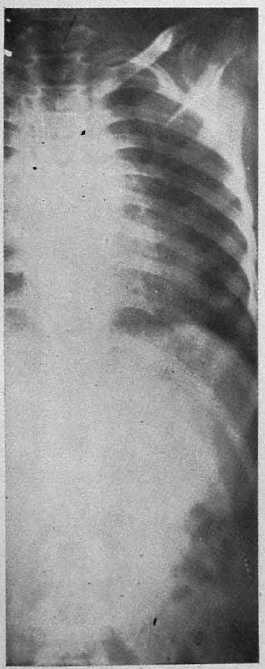


FIG. 4.

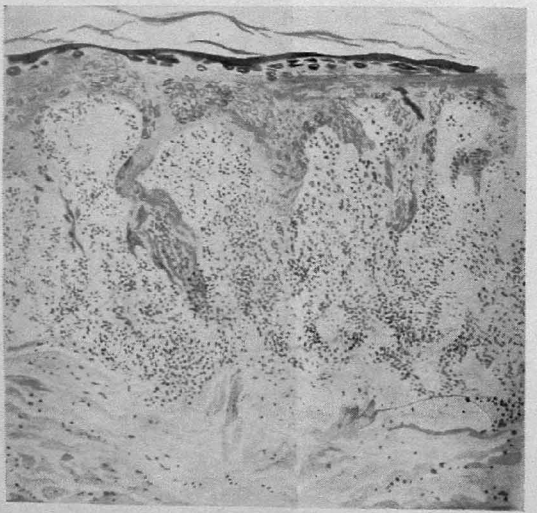
FIG. 5.

Figs. 4 & 5: Padmavathy — Caries D_5, D_6, and D_7 with abscess. Casto-transversectomy done (20—7—'62)

FIG. 6

Mrs. Seethalakshmi — 28 years F. Pott's Spine with paraplegia Costo-transversectomy done. Patient ambulant after 4 months with Taylor's brace.

OPERATIVE TREATMENT OF POTT'S SPINE — *K. A. Ramalingam*



HISTOPATHOLOGY :

The changes are very characteristic. There is a highly packed infiltrate of lymphocytes at the dermis hugging the epidermis.

The basal layer shows liquefaction. The prickle cell layer is slightly increased in thickness and the interpapillary process shows an irregular increase in length.

LICHEN PLANUS — *M. V. Venkatesan*

LICHEN PLANUS OF ERASMUS WILSON

T. V. VENKATESAN, M. B., B. S., F. A. D. S. (America),
F. A. I. M. (Skin), F. C. C. P. (U. S. A.), F. I. A. A., F. A. C. A., F. D. S. (Lond.),
Honorary Physician (Skin) & Consultant (Skin) E. S. I., Erskine Hospital, Madurai.

Lichen planus is one of the commonest of the skin diseases, but ranks high amongst the less common. It is the cause of much itching and discomfort.

Aetiology and Incidence: The cause of lichen planus is quite unknown. The epidermis is first affected by some irritants. Changes are seen at the basal cell layer. This has suggested a viral aetiology, though there is no definite proof. Psychological stress may aggravate the disease.

An important observation has been the development of lesions along the scratch lines in predisposed individuals. This is called Koebner's phenomenon. Lichen planus, thus, may develop in the site of herpes zoster, in an area which has been treated intensively with x-ray or ultra violet light and also in an abrasion.

At the Dermatology Department of the Government Erskine Hospital, Madurai about 150 new cases per year have been registered.

Diet habits: More cases have been registered among vegetarians than among non-vegetarians, the ratio being 4 : 3.

Age group: Maximum incidence is encountered in adults than in children.

Social status and occupations: The condition has been found to be more common in officers doing administrative work and also among students preparing for examination.

History of allergy: No history of asthma, urticaria, or nasal allergy has been noted in these cases.

Sex: Slightly more common in men than women-in the ratio of 6 : 4.

Clinical features: The onset is usually insidious and it may be weeks before the patient seeks medical therapy. But occasionally acute cases may develop rapidly and may become generalised in a few days. The lesions consist of shiny, flat-topped violaceous polygonal papules varying in size from pin point to 1 mm. The lesions occasionally coalesce forming larger areas of different shapes and sizes. Some of the papules show central umbilication. The diagnostic feature of lichen planus is the demonstration of Wickham's striae, which can be shown by moistening the papules with oil, revealing a fine bluish white net work.

Site: The eruptions favour the flexor aspects of wrists, forearms, inner aspects of legs, the penis, the scrotum, the base of the spine, mucus membrane of the mouth, the tongue and vermillion border of the lips. Face is not involved usually, but if lesions do occur, they are large, flat, deeply erythematous suggesting lupus erythematosus.

CLINICAL TYPES:

1. *Acute generalised lichen planus:* In this eruptions occur suddenly over the abdomen, back, thighs and forearms. Koebner's phenomenon is very common in this condition.

2. *Lichen planus hypertrophicus:* This consists of lesions which are thick and enlarged giving a warty appearance with violaceous colour. The usual site is on the legs, but may occur on the palms and soles.

3. *Lichen planus obtusus:* This is the term applied to a form in which rounded or oval or slightly convex papules occur on the arm or forearm.

4. *Lichen planus linearis:* This is a condition in which papules form linear groups and are seen along the course of a nerve in a segmental arrangement.

5. *Lichen planus annularis:* In this the papules extend peripherally leaving a clear centre and thus forms circular patches or rings. Annular lichen planus favours the penis, scrotum, lower parts of the back, the inner aspect of the thighs and the ankles.

6. *Lichen planus pilaris of Pringle* · Indicates a follicular arrangement of lesions with loss of polygonal shape (a dome shaped appearance). The condition occurs on the scalp or in groups on other parts of the body.

7. *Lichen planus of the mucus surfaces:* The mucus surfaces affected are: Buccal mucosa, vermilion border of the lips, epiglottis, vagina, glans penis and the anal mucosa. The change often seen is a reticulate pattern of white lines or white plaques. The mucus patches occuring are designated as "muco-keratosis buccalis". On the tongue the white plaques are slightly depressed.

Mucous membrane lesions seldom cause much discomfort, but when severe, may be painful and the patient complains of a dry feeling in the mouth.

8. *Lichen planus of the nails:* Most commonly there is a thinning of the nail plate. Longitudinal striations have been reported.

9. *Lichen planus pigmentosa - Sine Lichen:* It is an unusual variant described by Dr. Desai with mottled bluish black pigmentation of slaty colour.

HISTOPATHOLOGY:

The changes are very characteristic. There is a highly packed infiltrate of lymphocytes at the dermis hugging the epidermis.

The basal layer shows liquefaction. The prickle cell layer is slightly increased in thickness and the interpapillary process shows an irregular increase in length. Often they are pointed at the lower end giving the socalled sawtooth appearance. The granular layer is increased in thickness. The horny layer shows a moderate increase in thickness.

DIFFERENTIAL DIAGNOSIS:

The typical lesions of lichen planus are typical which means they present no difficulty. Lichenoid drug eruptions occuring after atebrin and gold may simulate lichen planus. Lichen planus hyphertrophicus may be difficult to be distinguished from lichen simplex chronicus (or neurodermatitis circum-scripta of Brocq). In a fully developed lesion, Brocq describes three zones: (1) An external ill-defined zone consisting of minute brownish papules. (2) a middle zone in which the lesions are discrete towards the outer zone and confluent towards the centre. (3) The central zone consists of flattened, smoothened or glistening papules. Where there is difficulty, a biopsy will settle the diagnosis.

A hypertrophic patch may also be mistaken for psoriasis, if the lesions occur on the elbows and knees. Occasionally psoriasis and lichen planus may co-exist.

Lichen planus linearis may be mistaken for the uncommon condition called lichen striatus. In lichen striatus the lesions occur usually in children; they are linear papular lesions in the upper extremities, unilateral in distribution and with no subjective symptoms.

Mucus membrane lesions in lichen planus have to be distinguished from leukoplakia, moniliasis and smoker's keratosis.

PROGNOSIS :

The duration of the disease is variable. A few cases may take 3 months, while others may take as much as one year. Hypertrophic lesions take a long time and pigmented lesions take a longer time.

TREATMENT :

The object of therapy in lichen planus is to relieve itching and to suppress the symptoms, while the body as a whole improves. In the acute forms of the disease, steroids are indicated. They relieve the great distress and itching and suppress the lesions during the period of their administration in adequate doses. An average case requires 20 mgm of prednisolone, or 16 mgm of triamcinolone per day for 10 days, after which the dosage can be diminished gradually and finally discontinued completely.

1. Palliative treatment with small doses of barbiturates or tranquillisers play a beneficial role.

2. In the milder cases, bismuth salicylas in oil 1 cc I. M. once in a week produces reversion of the symptoms.

3. Chloroquine phosphate tablets 250 mgm twice a week for one week and then once a week for three weeks has been tried.

4. Topical therapy has not been satisfactory except for the localised lesions. Hydrocortisone ointment 0. 25 to 1% is helpful. Dexamethasone spray has been especially used in mucus membrane patches. Superficial therapy is helpful in solitary hypertrophic cases. I have found good results with intradermal injections of hydrocortisone acetas 0. 1 to 0·2 cc in several areas surrounding the hypertrophic plaques.

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HEALTH SERVICES IN HUNGARY*

— Contributed on the occasion of the 18th anniversary of Hungary's liberation day — 4th April, 1963.

Hungarian medical science can boast of significant achievements attained over the last two hundred years or so. To mention but a few of its prominent representatives: Janos Adam Segner (1704—1777), physician and physicist, who owes his world fame to the wheel which has been named after him, Prof. Denes Benczur (1859—1896) was the first physician in the world to apply the heat respiration cure; and Ignac Semmelweiss (1818—65) has written his name in the annals of medicine as the conqueror of puerperal fever.

Yet, for all these achievements, medical services prior to Hungary's liberation in 1945 were far from satisfactory as far as the majority of the population was concerned – the annual TB death toll was 40,000, hospital beds were few, less than one-third of the population were covered by the social insurance scheme, and the infant death-rate was 2·7 for every 100 new-born infants.

These conditions got changed radically with the establishment of People's Democracy in Hungary.

The most significant change is in the remarkable expansion of the scope of social insurance – it now covers 80 per cent of the population as against 31 per cent in 1938; and this proportion is steadily being shifted towards the goal of 100 per cent social insurance for the entire population, since the rapid progress of the co-operative farm movement will in time have brought the whole of the peasantry under its scope.

The number of doctors in Hungary in 1938 was 10,580; latest figures show this number to have risen to 17,627. This means that Hungary's present ratio is 15·8 doctors for every 10,000 inhabitants – a ratio higher than that of France (10·4), or of Belgium (11·6), Denmark (11·6), or even of the German Federal Republic (13·9).

Doctors are trained in four universities. The education of one doctor involves an approximate expenditure of 150,000 to 200,000 forints by the state. Medical students attaining certain specified standards in their university work are awarded scholarship grants and, if justified by their financial position, free hostel services (board and lodging). The graduates are immediately assigned to well-paid jobs. They are required to serve an initial two-year term as some hospital staff to acquire experience necessary for district panel practice.

Physicians may engage in private practice - as a secondary occupation, as this is conditional on their taking employment on the State Medical Service as their principal occupation. Private practice is tied to no condition for physicians over 60 years of age, or if prevented by some sort of disability from working for the National Health Services.

* Courtesy — Embassy of the Hungarian People's Republic in India.

Because of its very wide scope, the National Health Services need the services of the entire medical profession. How imperative this need is may be seen from the fact that the number of the hospital beds in this country has grown from 46,922 in 1938 to well above 71,000 in 1960. The death-rate has dropped from 3·8 to 1·5 per cent.

What are the services enjoyed by the beneficiaries under the Hungarian Social Insurance Scheme?

First of all free medical services for the insured as well as their dependents, free hospitalisation for one year (two years for TB patients), incapacitated workers get sick benefits equivalent to 75% of full pay upto one year.

Maternity leave with full pay is granted for 20 weeks. It should be noted that maternity-home births account for 100 per cent births in Budapest whereas the figure in the countryside is 70 per cent. The number of mother-and-child nurses has risen from 344 in 1938 to 2,600 in 1960, while creche accommodation has increased from 1,000 in 1938 to 30,000-an increase of 30-fold-and is being augumented daily.

What is the foundation on which the medical services in Hungary are built?

The social insurance beneficiaries may avail themselves of the services of district panel doctors, or they may receive specialist treatment at the district consultation centres or in hospitals. These rights are laid down in the Social Insurance Act and also in other law-decrees. Thus, the Constitution and the Statute of Labour ensure the institutional organisation of works hygiene and safety measures, regulate working hours, guarantee special protection for young workers and women workers, restrict overtime and night hours, guarantee the right to paid holidays and recreation, etc. Some 70 regulations govern efforts to prevent occupational diseases and accidents on the job alone.

To promote the specialisation of health science, a National Institute of Labour Hygiene and an Institute of Dietetics were set up in 1949, and a network of public health and anti-epidemic centres was organised in 1954. The Institute of Labour Hygiene has made a total of 186,000 examinations on 60,000 workers in one year, thus making considerable contributions to researches in labour psychology, muscular functions and occupational diseases.

As health protection was being extended to cover new and new sections of the population, a great number of special therapy clinics sprang up over the last few years. Since it was opened at Pech two years ago, a children's heart clinic has made more than 13,000 examination of 5,000 child patients.

Hungary's first premature-births clinic has been functioning for ten years in Budapest. Experience gained by the staff of this clinic has served as a basis on which such clinics have been opened in all the hospitals throughout the country. In the Budapest hospitals 350 to 400 premature infants are helped to survive each year.

District panel doctors in industrial and mining regions enjoy a more favoured position-this is evident from annual bonus of 6,000 to 10,000 forints which they receive over and above their salary.

The rapid improvement of public health in Hungary has been due besides the revolutionary transformation which has been changing the social fabric of national life as well as substantial government subsidies - first of all to the high professional ability of Hungarian physicians and their devoted, diligent efforts in serving the people. For these dedicated efforts Hungarians are deeply grateful to their doctors and health workers in general. Year after year more doctors are awarded the "Kossuth Prize" – the highest state award in Hungary – and other state decorations. The freedom of healing is officially guaranteed, so long as it is consistent with the general progress of medicine at any given time, in all fields in which the practising doctors have acquired proper qualification and experience. It is another sign of official appreciation of their work that within 3 years doctors have had their salaries raised by considerable sums. Future still holds better prospects for the population as well as for the doctors in improving the health of the people.

THE 11th MADRAS STATE OPHTHALMIC CONFERENCE 1963

The 11th Annual Conference of the Madras State Ophthalmic Association will be held on Saturday the 10th and Sunday the 11th August, 1963 at the Trichy Medical Association Buildings, Salai Road, Woriur, Tiruchy. Dr. V. K. Chitnis, D. O., F. C. P. S., Bombay has kindly consented to preside over the conference

A souvenir containing useful articles, abstracts, and case notes will be published on the occasion. Doctors wishing to contribute articles, case notes, abstracts, etc for the souvenir are requested to contact the undersigned.

Advertisers are requested to send their advertisement materials well in advance to the undersigned.

Those ophthalmologists who have not yet become members of this association are requested to contact the treasurer, Dr. A. A. Sathar, L. O., 218, West Masi St., Madurai or the undersigned and become members of the association.

For further particulars please contact the Secretary, The 11th Annual Conference of the Madras State Ophthalmic Association, 48, Puthur High Road, Tiruchirapalli-1.

T. V. Ranganathan,
Secretary.

ABSTRACTS AND EXCERPTS

SMOKING AND HEALTH:

Cancer of the lung is now causing over 20,000 deaths each year in men in the United Kingdom and about 3000 deaths in women, and its incidence in heavy cigarette smokers is about thirty times that in non-smokers. The curve is a steeply rising one and does not show any safety zone. Even those who smoke about eight or ten cigarettes a day have something like ten times the likelihood of dying from cancer of the lung. The heavily polluted atmosphere of some of Britain's industrial areas adds to the dangers but cannot possibly be the cause of a death rate which rises so accurately with the number of cigarettes smoked. It has been said that the casual connexion between cigarettes smoking and cancer of the lung is not yet proved because animal experiments have failed to reproduce the human disease, but as the President of the Royal College of Physicians of London pointed out in a broadcast, all the crucial experiments have been done, and they could hardly have been better designed, but they have been done on human beings instead of on animals: for instance, there are the prospective surveys of Doll and Hill on British doctors, and of Hammond and Horn on American men aged 50—69, and of Dorn on American ex-service men aged 30 and over. In all these, a large number of men whose smoking habits had been recorded, were then followed over a number of years, and all three studies confirmed that the incidence of cancer of the lung depended upon the number of cigarettes smoked. Secondly, with a few minor discrepancies, the incidence of cancer of the lung in different countries varies with the smoking habits and not with the degree of atmospheric pollution. This, for instance, is seen in a comparison between Finland and Britain. Thirdly, in countries where smoking has been more recently introduced, the death rate from cancer of the lung is now beginning to rise; and fourthly, perhaps most importantly, giving up smoking appreciably lessens the risk of cancer of the lung.

Perhaps, what is less generally known is the greatly increased death rate, especially in the younger men, from coronary heart disease in heavy cigarette smokers and, of course, in Britain, the greatly increased death rate from chronic bronchitis. These various hazards of cigarette smoking, combine to give a man of 35, who is a heavy smoker, three or four times the likelihood of dying before he is 55, of that of a non-smoker of the same age. Another striking fact which comes out of the report is that British doctors have significantly changed their smoking habits over the last ten years, so that more than 50 per cent of them are now non-smokers, although 75 per cent of the general male population smoke. Only 25 per cent of doctors now smoke cigarettes. The risk for smokers of cigars and pipes is, of course, very much less than that for cigarette smokers.

Assuming the case to be proved, the remedy is more difficult. A large number of people are addicted to the habit of cigarette smoking and find it impossible to give it up. To put a crippling tax on their cigarettes,

which are already very expensive, might mean very serious hardship to middle-class families with young children. Perhaps, the most important thing is that there should be a change of attitude towards smoking and that people who smoke cigarettes should be apologetic about it in the future instead of trying to pretend that it is something which all sensible people do. But what stands out more than anything is that all adults, whether doctors or not, should face the facts and try to prevent the next generation from becoming addicts to the cigarette habit. The Royal College of Physicians' report pointed out that in the years 1956 to 1960 the Central Council for Health Education and the local authorities in Britain spent less than £ 5000 on anti-smoking education while the tobacco manufacturers spent £ 38,000,000 on advertising. Surely the manufacturers' attempts to spread the habit amongst teenagers and College men and in the developing countries should be looked upon with the gravest disapproval. If they continue, the manufacturers would only have themselves to blame if some legislative action against the advertising of cigarettes was introduced.

— R. Platt : Journal of Chronic Diseases, **15**, *pp. 1001—1002. (1962) Professor of Medicine, University of Manchester.*

* * * *

TREATMENT OF PREGNANCY TOXAEMIA :

Striking improvement in the maternal mortality rate due to toxaemia of pregnancy is largely attributable to the introduction of the thiazide derivative diuretics, according to I. Siegel (American Journal of Obstetrics and Gynecology, November 15. 1962, 84, 1343) who reports the results obtained with a new drug of the same class, namely bendrofluazide. This preparation is said to be 100 times nore potent, milligram for milligram than chlorothiazide and to promote diuresis with augmented urinary excretion of sodium and modest potassium loss. Its hypotensive action is about the same as that in other benzothiadiazine derivatives. In the study reported the drug was administered orally in 10 mg doses once daily to 26 hospitalized patients with pregnancy toxaemia whose ages ranged from 14 to 44 years. Sixteen of them were judged to be in a true pre-eclamptic state. A fall in blood pressure was achieved in all (average 48·7 mm Hg systolic and 28·7 mm Hg diastolic), oedema disappeared or was considerably diminished, weight loss ranged between 2 and 31 pounds (0·9 and 14 kg) with an average of 11·8 pounds (5·2 kg). Proteinuria, initially heavy in the majority, either disappeared or showed a great improvement. There were six stillbirths, none of which was considered to be related to bendrofluazide administration. Four of these infants were born to mothers who had severe chronic hypertension. The series included one neonatal death which was ascribed to prematurity and atelectasis, It is suggested that once the best therapeutic result has been gained, termination of the pregnancy should be considered, if the foetal maturity is thought to be sufficient to enable survival because, although treatment can improve the maternal prospects greatly, the risk to the baby may still be substantial.

— The Practitioner : Vol. 190, Page 291.

PREGNANCY ANAEMIA:

Anæmia in pregnancy has been discussed once again at the British Congress of Obstetrics and Gynæcology held in Bristol in July 1962 and in other reports.

Witts draws attention to some of the problems. During pregnancy both plasma and red-cell volumes increase, but the plasma-volume increases more than the red-cell volume: Witts cites figures showing that, "while the total hæmoglobin mass increases on the average from 550 g at the beginning of pregnancy to 725 g in the 7th month, the hæmoglobin concentration drops over the same period from 13·4 to 11· 6 g per cent". At what level of hæmoglobin concentration can anæmia be presumed to be present? Another question is posed by what Witts calls the pharmacological action of iron: if iron is given to pregnant women and their hæmoglobin level rises, they are usually assumed to have been deficient in iron; but Witts points out that iron in the therapeutic doses stimulates erythropoiesis and can cause the haemoglobin level to rise in the non-anæmic. Nevertheless much evidence points to a high frequency of undeniable iron deficiency in pregnancy. A survey of women aged 15-44 in a rural population in this country showed that a quarter of them had a hæmoglobin level of less than 12g per 100ml.; and study of marrow smears for iron and of serum-iron levels showed deficiency in 11 out of 12 women. Work in Witts' department has shown that iron stores are commonly inadequate even in women with hæmoglobin over 12g per 100 ml. There seems to be good reason for prescribing iron for any pregnant woman whose hæmoglobin level falls below 120 g per 100ml (82%). Yet another problem is megaloblastic anæmia in pregnancy: Giles and Shuttleworth in Stoke-on-Trent reported that this had an incidence of 2·8%. In this country such anæmia is almost always due to folic-acid deficiency; and folic-acid-clearance studies have indicated increased clearance of folic acid from the plasma as early as the 12th week of pregnancy, though clearance is maximal in the last 3 weeks. These findings suggest that megaloblastic anæmia occurs in pregnancy because the mother's stores of folic acid, together with what she absorbs from her food, are inadequate for both the foetus and herself. But Witts points out that the daily minimum requirement of folic acid is very small (of the order of 5 ug) and large doses of folic acid (20 mg daily intramuscularly) are known to be needed to reverse megaloblastic anæmia. These facts suggest an unusual resistance to folic acid rather than a simple deficiency. There is some evidence that prophylactic administration of folic acid can greatly reduce the incidence of megaloblastic anæmia in pregnancy, but there is little point in giving the folic acid before the 6th month since only 4% of cases are diagnosed before the 30th week. Witts believes that the risk of provoking neurological changes in an undiagnosed case of pernicious anæmia is not great.

Solomons *et al.* in New York used serum-folic acid assays to assses the changes during pregnancy and relate them to the incidence of megaloblastic anæmia. They confirmed that folic-acid levels below the accepted normal were common in the third trimester of pregnancy, especially among

the " underprivileged "; but megaloblastic anæmia was very rare and was unrelated to the degree of folic-acid deficiency. They conclude that some factor other than folic acid deficiency must be involved. Hibbard found excretion of formiminoglutamic acid (Figlu) a useful screening test for folic-acid deficiency in pregnancy : of 157 women tested, 83 gave normal results and had normoblastic marrow; 54 excreted *Figlu* in excess and were found to have megaloblastic marrow; the remaining 20 had excess *Figlu* in the urine with normoblastic marrow, but their anæmia resolved and *Figlu* disappeared from the urine when folic acid was administered. Lewis *et al.* describe a simplified form of the *Figlu* test in which histidine loading was not needed; but this method seems to give many more false positives than the usual technique.

Lawrence re-examined the methods used for determining the iron status in pregnancy, and concluded that this could be best assessed by estimating the serum-iron concentration and examining a marrow smear for stainable iron; the mean corpuscular hæmoglobin concentration and the appearance of stained red cells were relatively insensitive indicators. He draws attention to the condition in which the hæmoglobin level was reduced below 12 g per 100 ml but tests showed an iron-sufficient state. Such patients have an unusually large increase of blood-volume and, therefore, treatment by blood-transfusion should be avoided; nor is there any point in giving them parenteral iron injections since they are not iron-deficient. Lawrence, like Paintin, considers that a hæmoglobin level below 10 g per 100 ml (70%) denotes anæmia. Giles and Brown have pointed to the frequency of urinary infection in pregnancy and the retarding effect of infection on response of anæmia to treatment : often the patient's infection gives rise to no symptoms and is detected only when specifically sought. Urinary infection was found to be twice as common among anæmic patients as among others, *Escherichia coli* being as usual the commonest infecting organism. Antibacterial drugs cleared the infection in 30 out of 56 patients, and in 26 of these 30 there was a concomitant rise in hæmoglobin level.

The present trend in management of pregnancy anæmia thus seems to be that treatment should alawys be applied if the hæmoglobin level falls below 10 g per 100 ml (70%) and that the treatment in the last three months of pregnancy might well include administration of folic acid as a prophylactic against possible development of megaloblastic anæmia. The hæmoglobin level seems to have been rehabilitated as a guide to anæmia in pregnancy, but in anæmic cases examination of the marrow for cellular changes and assessment of iron content is always worth undertaking. Regular estimation of hæmoglobin, now practised in many antenatal clinics, and treatment when indicated, seems to be more rational than mass handing out of iron and folic-acid pills. For detection of megaloblastic anæmia, examination of bone-marrow smears remains the most reliable test; but, where the technique is available, the *Ftglu* excretion test is a valuable indicator of impaired folic-acid function and provides a warning that megaloblastic anæmia may develop.

— The Lancet : Editorial, February, 9, 1963, pp. 309 & 310.

LETTERS TO THE EDITOR:

To

The Editor,
Madras Clinical Journal, Coimbatore.

Dear Sir,

I am in receipt of the 25 reprints of my article published in your esteemed Journal. The article was brought out in an excellent manner and the credit goes entirely to you.

It was a real encouragement to me to work with new enthusiasm and vigour to take part in scientific discussions and otherwise. Since the publication of my article in the Madras Clinical Journal, I was invited by two other journals to contribute articles to them. It was an honour and privilege bestowed on me, to which I am very much indebted to you. Kindly accept my heartfelt thanks to you.

With esteemed regards,

Yours faithfully,

Dr. Joseph's Eye Hospital,
Tiruchirapalli.

(Sd.) J. RAJASEKARAN.

* * * *

INTEGRATION OF MEDICAL AND PUBLIC HEALTH DEPARTMENTS

Sir,

The State Minister for Health recently informed the Legislative Assembly that the Government had not yet taken any decision on the question of integration of the Medical and Public Health Departments though in other States there was a merger of the two departments. During the discussion some members of the Legislative Assembly opposed the integration of the two departments.

May I point out that it has been the concerted opinion of various international conferences and experts that the unitary system of health services under which curative and public health services are combined in one administrative unit with a bivalent personnel at different levels according to requirements is most desirable. This, on one hand, leads to economy in equipment and staff and at the same time ensures carrying out of a balanced programme with due regard to overall objective of preserving and promoting the health of the people while providing relief to the sick. The integration of both services radiating from health centres in rural areas is an ideal method and this is how the present idea of health centres was developed in India.

The fundamental solution to the problem of medical relief would be the prevention or retardation of illness and promotion of health. This reorientation is to be realised in attempts to provide medical care to the people. People should be made to realise that it is as important to seek the advice of their physician on how to keep well as it is to call upon him for help when illness strikes. Preventive medicine, therefore, cannot be a separate service conducted quite apart from other medical services. Preventive and clinical medicine must be closely integrated if the positive health level of the people is to be raised, and only when this is accomplished will the extension of more and better medical service be fully effective.

32, Thennamaram Street, Vellore,
25th March 1963

(Dr.) T. M. KUMARASWAMI.

THE 39th ALL INDIA MEDICAL CONFERENCE

The 39th All India Medical Conference will be held at Madras city during the last week of December 1963 under the auspices of the Indian Medical Association, by the Madras City Branch of the Indian Medical Association which has invited the conference. The Madras City Branch of I. M. A. is forming the Reception Committee for the successful and proper conduct of the conference.

2. It is proposed to have the usual scientific sessions, an exhibition of medical and surgical appliances and pharmaceutical products, and an attractive souvenir to commemorate the occasion; and details of all these are being worked. A unique feature of this year's conference will be the inauguration of the "Dr. C. S. Thakkar Oration Award" and the conferment of the first award.

3. In sending this circular letter it is my desire to give you an advance intimation of the proposed conference and to enlist your full support and active co-operation with the host branch. The success of the conference depends upon the delegates and visitors attending the same; and I wish that the full number of delegates permissible to your branch under the rules will attend and take part. It is our wish to arrange a good scientific fare; and here again I request your co-operation in making available to us a good number of scientific papers to be read and discussed.

4. May I request you to kindly pass on this information to all your colleagues in the profession and give us your active help and co-operation and offer your suggestions to make this conference a grand succes?

National Insurance Buildings,
362, N. S. C. Bose Road,
(China Bazaar Road)
Madras - 1

D. DAMODER DAS,
Secretary.

NEWS AND NOTES

CYANAMID DONATES FURTHER Rs. 50,000 TO NDF

Bulsar, March 29: Cyanamid India Ltd., an Indo-American enterprise, manufacturers of Lederle Pharmaceuticals and other agricultural and animal health products, today made a further donation of Rs. 50,000. to the National Defence Fund.

At the end of October 1962, during the first weeks of Chinese aggression, Cyanamid announced their first donation of 100,000 capsules of Ledermycin, a life-saving antibiotic for the use of our fighting jawans.

At a brief ceremony at the Cyanamid plants here today, Mr. William Parker, Managing Director of the firm, formally presented a cheque for Rs. 50,000 to Mr. S. M. Dudani, Collector of Surat. Mr. Parker said that "the world has been shocked at the unprovoked Chinese aggression on India, one of the great democracies in the world striving for peace", and expressed the hope that by the magnificent effort the Indian people are making they will eventually repel the aggressor from Indian Soil.

OBITUARY

Dr. H. C. Berlie, a deeply loved and highly respected general practitioner of Coonoor, passed away on 28—2—1963 at the age of 78 years.

Since he retired in Coonoor in 1947, he was an active member of the Nilgiri District Branch of the Indian Medical Association and its president during the year 1956—'57.

Earlier in his career he served in the British Consular Service in the Persian Gulf. While serving as Chief Medical Officer of some large tea plantations in Assam, he was actively connected with the Assam Branch of the British Medical Association. He was a member of the Central Committee of the Pasteur Institute, Coonoor.

In his work he maintained very high standards. No trouble was too much for him for any of his patients. His memory will remain in the hearts of his patients and all those who had the good fortune to know him.

THE 17th MADRAS STATE MEDICAL CONFERENCE, 1963

PROGRAMME

Saturday, the 27th April 1963

8-00 A.M. Breakfast & Registration.

8-45 A.M. Flag Hoisting:
National Flag
I. M. A. Flag
Prayer
Welcome Address — Dr. K. Rangaswami
Inauguration of the Conference — Dr. C. P. Ramaswami Aiyer
Presidential Address — Dr. C. Nathamuni Naidu
Presentation of Souvenir
Reading of Messages
Vote of Thanks
National Anthem

11-00 A.M. Meeting of the State Council

1-00 P.M. Lunch

2-00 P.M. Inauguration of the Scientific Sessions
President's Introductory Remarks
"Major Complications in Coronary Thrombosis and its Management" — Dr. Ratnavelu Subramaniam, M.D., M.R.C.P.
"Diabetes" — Dr. Sam G. P. Moses, M. D.
"Surgery of Oesophageal Obstruction"
— Dr. C. S. Sadasivam, M. S.

4-00 P.M. Tea

4-30 P.M. "Congenital External Mal-formations and Their Management"
— Dr. M. S. Ramakrishnan
"Infantile Cirrhosis" — Dr. V. Balagopal Raju, M. D., D. C. H.
"Pyelo-Nephritis" — Dr. A. L. Annamalai, M. R. C. P., D. T. M. & H.

8-00 P.M. Dinner

9-00 P.M. Entertainment — Film Show

Sunday, the 28th April 1963

8-30 A.M. Breakfast

9-30 A.M. "Recent Advances in Gynaecology and Midwifery"
— Dr. Joseph, M. D.
"Have Venereal Diseases Reached the Villages"
— Dr. P. N. Rangaiah, M. D.
"Surgery in Deafness" — Dr. C. Sathyanarayana, M. S., D. L. O.

12-00 Noon Lunch

1-00 P.M. "Epilepsy" — Dr. B. Ramamurthy, M.S., F.R.C.S.
"Eczema — Present Concept and Management"
— Dr. M. Natarajan, M.B., B.S., F.D.S., Z.D.V., (Vienna)
Subject to be announced — Dr. R. Chandravadana,
F.R.C.S., M.R.C.O.G.

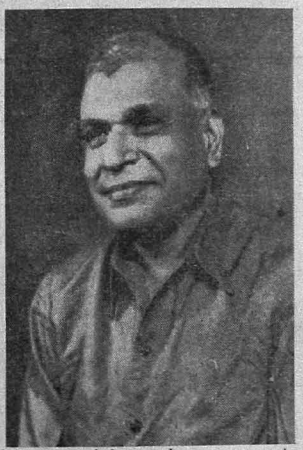
4-30 P.M. Open Session of the Conference

5-00 P.M. Tea &
Vote of Thanks.

OBITUARY

LIFE SKETCH OF Dr. P. S. RAMASWAMY, M.B., B.S.

Dr. P. S. Ramaswamy, M.B., B.S., National X-Ray Institute, Salem died of a heart attack on 16—3—1963. He was born in 1900 at Palghat in Kerala State in an aristocratic family and had his early education at Ernakulam. He graduated in Medicine and Surgery from the Medical College, Visakhapatnam. After undergoing post-graduate training at Bangalore, he started practice at Salem in 1932. In 1933 even before the Government hospital had an x-ray plant, Dr. Ramaswamy started the National X-Ray Institute which served the needs of the entire district including the Government hospitals. He expanded this institute and had it equipped with the latest type of x-ray plants, electro-cardiogram, ultra short-wave therapy and other modern electro-medical equipment. He was an authority in his special field and was of immense help to all the doctors in the district and particularly to the younger members of the profession. Many a budding practitioner has reason to remember with gratitude the timely advice and help rendered to him by Dr. Ramaswamy.



Dr. Ramaswamy was associated with the Salem branch of the Indian Medical Association and was a past president of the Salem branch for more than one term. He was taking active interest in the association and guiding its activities. He had another interest in philosophy and puranic scriptures.

Dr. Ramaswamy's death has left a void in the ranks of the medical profession in the entire district of Salem. May his soul rest in peace!

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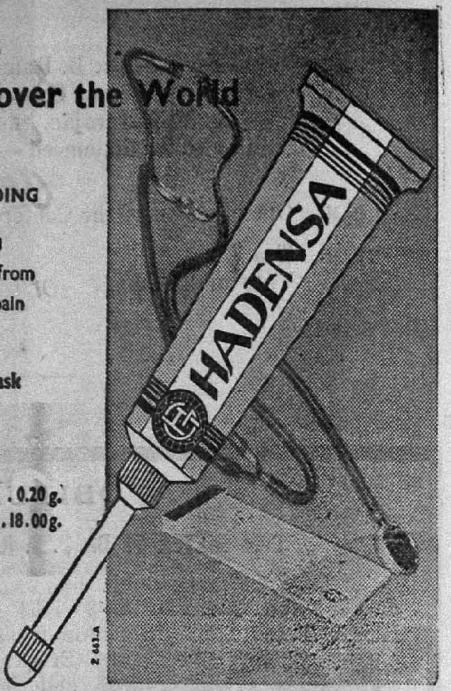

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